

## Conservation Employees' Benefits Plan

## **Tobacco-Free Attestation**

receive the discounted monthly insurance premiums. Please return to Human Resources Division/Benefits Section/Central Office.	
Please check the appropriate box:	☐ 2013 Retiree ☐ 2014
Subscriber Information & Attestation	
Name (Last, First, Middle Initial):	Social Security Number (last 4):
	XXX-XX
Address:	Date of Birth (MM/DD/YYYY):
City, State, Zip Code	
I will not use tobacco products through December 31, 2014. If I begin using tobacco products, I will notify Human Resources Division by phone, fax or mail immediately to adjust my monthly premium beginning with the next pay cycle.	
I understand that providing false information may subject me to repay the discount I received, and n Signature:	nay also subject me to fines and/or discipline.  Date (MM/DD/YYYY):
This Attestation will not be completed unless signed by the subscriber whose name appears above.	
Spouse Information & Attestation (if on the medical insurance plan)	
Name (Last, First, Middle Initial):	Social Security Number: (last 4):
	XXX-XX
Address:	Date of Birth (MM/DD/YYYY):
City, State, Zip Code	
I will not use tobacco products through December 31, 2014. If I begin using tobacco products, I will notify Human Resources Division by phone, fax or mail immediately to adjust my monthly premium beginning with the next pay cycle.	
I understand that providing false information may subject me to repay the discount I received, and n Signature:	nay also subject me to fines and/or discipline.  Date (MM/DD/YYYY):
	, , ,
This Attestation will not be completed unless signed by the spouse whose name appears above.	